UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION SEVEN

McLAREN MACOMB

Employer

and **Case 07-RC-243228**

LOCAL 40, RN STAFF COUNCIL, OFFICE AND PROFESSIONAL EMPLOYEES INTERNATIONAL UNION (OPEIU) AFL-CIO

Petitioner

DECISION AND DIRECTION OF ELECTION

Petitioner seeks to represent a unit of all full-time and regular part-time non-professional employees employed at the Employer's main hospital campus located at 1000 Harrington, Mount Clemens, Michigan; but excluding all other employees, managerial employees, temporary employees, contracted employees, confidential employees, guards and supervisors as defined in the Act.[1]

Petitioner's petition lists the following classifications comprising approximately 187 non-professional employees: anesthesia techs, bed coordinators, critical care techs, EKG techs, endoscopy techs, imaging assistants, lab courier aides, lab courier clerks, lab courier drivers, lab office clerks, lab pathology aides, lab phlebotomists, perioperative techs/pass techs pre-op, patient sitters/patient safety associates, and pharmacy techs. The parties agree that the bed coordinators are currently classified as bed control specialists; the EKG techs are currently classified as cardiographic techs; the lab courier aides, lab courier clerks and lab courier drivers are currently classified as couriers; the lab office clerks are currently classified as clerical associate-2s; the lab pathology aides and lab phlebotomists are currently classified as lab assistants; the perioperative techs/pass tech pre-ops are currently classified as perioperative techs; the patient sitters/patient safety associates are currently separately classified as patient sitter-2s and patient safety associates; and the pharmacy techs are currently classified as pharmacy tech-1s and pharmacy tech-2s.

Out of these petitioned-for classifications, the parties stipulated that the following employees should be included as non-professional employees in any unit found to be appropriate based on the nature of their non-technical, non-skilled maintenance, non-business office-clerical, and non-guard duties per Section 103.30 of the Board's Rules and Regulations governing appropriate bargaining units in the health care industry: bed control specialists; imaging assistants; and clerical associate-2s (formerly known as lab courier aides); lab courier clerks and lab courier drivers.

[1] As amended at the hearing.

The parties also stipulated that the following employees should be included as non-professional employees in any unit found to be appropriate: clerical associate-1s; all other clerical associate-2s; gift shop clerks; clinical care systems coordinators; office coordinators; dispatchers; couriers; EEG techs; operators[2]; patient liaison meta[3] bariatric; schedulers; surgical boarders; and surgical supply specialists. While the parties likewise stipulated that the patient sitter-2s and the patient safety associates are non-professional employees, the Employer argues that they must only be included in a unit which includes the patient care associates (PCAs) in the existing bargaining unit represented by Michigan District Council 25, and its affiliated Local 2569, American Federation of State, County and Municipal Employees, AFL-CIO (AFSCME) because they share an overwhelming community of interest.

Thus, the parties agree that any unit of non-professional employees found to be appropriate should include the following employees and classifications:

> bed control specialists; imaging assistants; clerical associate-1s; clerical associate-2s; gift shop clerks; clinical care systems coordinators; office coordinators; dispatchers; couriers; EEG techs; operators; patient liaison meta bariatric; schedulers; surgical boarders; and surgical supply specialists.

The Employer argues that the Petitioner's proposed unit is non-conforming under Section 103.30 of the Board's Rules and Regulations governing appropriate bargaining units in the health care industry and thus not appropriate for bargaining because (1) it does not contain *all* of its non-professional employees, and (2) it contains certain employees who are *not* non-professional. The Employer contends that the unit must include the following approximately 201 non-represented non-professional employees: academic program administrator-1s; academic program administrator-2s; biomedical tech-1s; biomedical tech-2s; biomedical tech-3s; billing clerks; medical staff services coordinators; graduate medical education specialists; inventory assistants; inventory coordinators; medical coders; patient access representative-1s; patient access representative-2s; patient access representative-3s; patient experience representatives; respiratory equipment techs; staffing coordinators; and systems specialists.[4] Petitioner disagrees that these employees are non-professional and argues, without specificity, that they are either business office-clerical, skilled maintenance, technical, or professional employees. In addition, the Employer argues any appropriate non-professional unit must include the non-professional employees currently represented by AFSCME. Petitioner disagrees and argues that it has petitioned for an appropriate "residual" unit of all non-represented non-professional employees.

The Employer further contends that the unit must exclude the following employees because they are technical employees: anesthesia techs, cardiographic techs, critical care techs, endoscopy techs, lab assistants, perioperative techs, pharmacy tech-1s; and pharmacy tech-2s.[5]

---

[2] The parties stipulated that the job description is "operators." For the sake of clarity, I note that the operators are what is often described as switchboard operators.

[3] Meta is short for metabolic.

[4] I note that the Employer's non-professional housekeeping and dietary employees are directly employed by a third-party contractor employer.

[5] At the hearing the parties stipulated that the position of health clinician is a technical position requiring the employee to be a licensed practical nurse (LPN) and based on job duties including performing patient exams

The parties agree that the following employees listed as exclusions in Petitioner's petition are not non-professional and should be excluded from any unit found to be appropriate:

> professional and managerial employees, including physicians and registered nurses (RNs); temporary employees; contracted employees; confidential employees; and guards and supervisors as defined in the Act.

In addition, the parties stipulated that the following classifications of employees are not non-professional and should be excluded from any unit found to be appropriate herein:

> Accountant II; cardiovascular invasive specialist reg; case manager RN; clinical information specialist; clinical pharmacy specialist; clinical specialty coordinator; computer tomography techno[6]; coordinated emergency preparedness; computer tomography techno lead; clinical transformation specialist; coordinated metabolic bariatric; coordinated surgical board; cytotechnologist; educator diabetes RN; educator patient care services; educator patient care service lead; executive assistant; executive assistant senior; exercise physiologist; imaging services instructor; infection preventionist; laboratory marketing rep; lactation consultant; librarian; mammography techno; mammography techno lead; marketing communication specialist; medical staff credentialing specialist; media relations specialist; medical laboratory tech; medical assistant; MRI technologist; MTQIP clinical reviewer; medical technologist; nurse extern; nurse intern; nuclear medicine technologist; nurse navigator breast health; nurse practitioner specialty; OB technician II; occupational therapist; pathologist assistant; pharmacist; pharmacist lead; pharmacy buyer; pharmacy intern; physical therapist; physical therapist assistant; physical therapist assistant lead; physician liaison; polysomnographic technologist; polysomnographic technologist lead; preadmission testing techs; program managers; clinical risk patient safety; quality improvement specialist; radiology technologist; RN first assistant; respiratory intern; respiratory therapist reg; respiratory reg lead; social worker MSW; sonographer; sonographer cardiac; sonographer cardiac lead ; sonographer lead; sonographer vascular reg; special procedure technologist; speech language pathologist; surgical tech; trauma data analyst; trauma performance IMP specialist; utilization review AP specialist RN; and utilization review specialist.

As discussed below, based on the record and relevant Board law, I make the following findings:

- the cardiographic techs, critical care techs, lab assistants, perioperative techs, pharmacy tech-1s, and pharmacy tech-2s are not technical employees, and should be included in the unit of non-professional employees found to be appropriate herein;

---

involving the use of independent judgment. There is currently one LPN in this classification who performs pre-employment physicals for new employees and physical examinations related to employee workers comp injuries.

[6] The record does not indicate whether "techno" is short for technologist or a separate classification.

- the administrative assistants, patient access representatives-1s, patient access representative-2s and patient access representative-3s, patient experience representatives, respiratory equipment techs, staffing coordinators and system specialists should be included in the unit of non-professional employees found to be appropriate herein;

- the anesthesia techs, endoscopy techs, academic program aministator-1s, academic program administrator-2s, graduate medical education specialists, medical staff services coordinators, audit analysts, billing clerks, inventory assistants, inventory coordinators, and medical coders shall be permitted to vote subject to challenge in the non-professional unit, and their voting eligibility will be determined, if necessary, in post-election proceedings;

- the biomedical tech-1s, biomedical tech-2s and biomedical tech-3s should be excluded from the unit of non-professional employees found to be appropriate herein;

- a separate residual unit of the remaining non-represented non-professional employees is an appropriate residual unit, and the stipulated non-professional patient safety associates and patient sitter-2s should be included in such unit found to be appropriate herein.

I. Procedural Issues

A. Rulings on the Parties' various Motions and Offer of Proof

Before the hearing commenced, the Employer filed a Statement of Position with an attached list of employees in mutually proposed classifications. At that time, the Employer understood the petitioned-for unit to be a unit of solely technical employees. On the second day of the hearing, the Petitioner clarified its position as to the petitioned-for employees and moved to amend its petition to include all non-professional employees, which I granted. The Petitioner then made a motion to compel the Employer to immediately file an amended Statement of Position to conform to the amended petition and include a new list of employees in the proposed classifications. The Employer responded that it would agree to verbally amend its Statement of Position at the hearing and, if necessary, compile a new employee list within two business days. I granted the Petitioner's motion and ordered the Employer to file an amended Statement of Position with accompanying employee list within two business days. The Employer complied and filed its amended Statement of Position with accompanying employee lists as ordered.[7]

The Employer also attempted to place evidence into the record that an AFSCME-represented employee/local AFSCME official solicited the international AFSCME organization to intervene as an interested party in this proceeding without any success. I rejected this evidence and offer of proof. I find that such evidence is speculative and should not be considered.

[7] The Employer's amended Statement of Position, with attachments, were identified and received into the record and are being made a part of the official record.

B. Rulings on Subpoena Issues

Also on the second day of the hearing, in light the Employer's position that Petitioner's proposed amended unit must include additional non-professional employees not listed in the petition, the Petitioner served a subpoena duces tecum for certain documents related to job descriptions and job postings for such employees asserted by the Employer to be non-professional. The Petitioner then moved to compel the Employer to immediately respond to its subpoena duces tecum and/or provide the requested documents. The Petitioner argued that the Hearing Officer has the authority and discretion to order the production of documents requested via subpoena in a shorter time period that than set forth in the Board's Rules and Regulations. The Petitioner renewed its motion on the sixth day of hearing, at the conclusion of the Employer's record testimony and evidence and prior to the commencement of Petitioner's presentation of record testimony and evidence. I denied the Petitioner's motion and the Petitioner responded that it would proceed under protest.

Section 102.31 (b) of the Board's Rules and Regulations states that "…[a]ny person served with a subpoena, whether ad testificandum or duces tecum, if that person does not intend to comply with the subpoena, must, within 5 business days after the date of service of the subpoena, petition in writing to revoke the subpoena. …" The hearing concluded on the eighth day without further discussion about this matter. I note that many, if not all, of the documents requested by the Petitioner in its subpoena duces tecum were entered into the record by the Employer during its presentation of evidence. Petitioner did not object to the relevance or admission of such documents.

C. Ruling on the Motion to Close the Record

The Employer concluded its record testimony and evidence on the sixth day of the hearing, a Friday afternoon. At that time, the Petitioner was not prepared to immediately commence its presentation of record testimony and evidence. The Employer moved to close the hearing based on the Petitioner's unreadiness to proceed. In this regard, the Petitioner acknowledged that it requested 15 ad testificandum subpoenas from the Hearing Officer on the day before in anticipation of commencing its case soon thereafter. However, Petitioner raised the issue of difficulty in tracking down and calling witnesses at the end of the week during the summer while Employer's case was ongoing. Petitioner advised the Hearing Officer of its commitment to proceed on the next day. The Hearing Officer denied the Employer's motion to close the hearing on June 28 and the hearing proceeded on July 1 without incident. I affirm the Hearing Officer's June 28 ruling.

II. The Employer's Operations and Employee Representation/Bargaining History

The McLaren Health System operates numerous hospitals throughout the state of Michigan including the Employer's acute care hospital in Mt. Clemens, Michigan. The Employer also maintains an off-site office building known as the Glass House in which its payroll and finance departments comprising the central business office (CBO) are located. There is also limited record evidence that there are several off-site physician practice sites maintained

by the Employer, however, those sites are operated autonomously and do not involve any of the employees in question in this proceeding.

AFSCME currently represents certain non-professional employees employed by Employer including patient care associates/PCAs, boiler operators, carpenters, , point of service clerks, electricians, maintenance mechanics, medical equipment assistants, painters, patient transporters, plumbers, sterile process operators, stores clerks, and unit clerks. The current CBA between the Employer and AFSCME expires on December 1, 2021.

Michigan Association of Police (MAP) currently represents approximately 27 security officers employed by the Employer. The current CBA between the Employer and MAP is effective from December 17, 2017 through December 16, 2020.

Petitioner currently represents a bargaining unit of RNs employed by the Employer. The current CBA between the Employer and Petitioner is effective from July 28, 2018 through July 27, 2021.

III. Analysis

A. Applicable Board Law

When examining the appropriateness of a unit, the Board must determine not whether the unit sought is the only appropriate unit or the most appropriate unit, but rather whether it is "*an* appropriate unit." ***Wheeling Island Gaming,*** 355 NLRB 637, 637 n.1 (2010) (emphasis in original) (citing ***Overnite Transportation Co.***, 322 NLRB 723 (1996).

In determining whether a unit is appropriate, the Board looks at whether the petitioned-for employees have shared interests. See ***Wheeling Island Gaming***, supra. Additionally, the Board analyzes "whether employees in the proposed unit share a community of interest *sufficiently distinct* from the interests of employees excluded from the unit to warrant a separate bargaining unit." ***PCC Structurals, Inc.***, 365 NLRB No. 160, slip op. at 11 (December 15, 2017) (emphasis in original).

In making these determinations, the Board relies on its community of interest standard which examines:

> whether the employees are organized into a separate department; have distinct skills and training; have distinct job functions and perform distinct work, including inquiry into the amount and type of job overlap between classification; are functionally integrated with the Employer's other employees; have frequent contact with other employees; interchange with other employees; have distinct terms and conditions of employment; and are separately supervised.

PCC Structurals, Inc. 365 NLRB No. 160, slip op. at 11 (citing ***United Operations***, 338 NLRB 123 (2002)).

Of note, in contrast to the Board's standard under ***Specialty Healthcare & Rehab. Ctr. of Mobile,*** 357 NLRB 934 (2011) "at no point does the burden shift to the employer to show that any additional employees it seeks to include share an overwhelming community of interest with employees in the petitioned for unit." ***PCC Structurals Inc.***, 365 NLRB No. 160, slip op. at 11. Rather, "parties who believe that a petitioned-for group improperly excludes employees whose interests are not sufficiently distinct from those of employees within the proposed group will […] introduce evidence in support of their position." **Ibid.**

Additionally, when applicable, the above analysis should consider the Board's established guidelines for appropriate unit configurations in specific industries. **Ibid**.

The Board's rule regarding appropriate units in the healthcare industry, 29 C.F.R. Sec. 130.30 ("Health Care Rule") sets forth the appropriate units for acute healthcare hospitals. This rule provides that, except in extraordinary circumstances, the following units and only these units are appropriate in an acute care hospital:

(1) All registered nurses.
(2) All physicians.
(3) All professionals except for registered nurses and physicians.
(4) All technical employees.
(5) All skilled maintenance employees.
(6) All business office clerical employees.
(7) All guards.
(8) All other non-professional employees.

However, the Health Care Rule specifically excepts from its coverage "existing non-conforming units," such as the existing nonconforming unit of AFSCME-represented non-professional employees in the instant case. See ***Crittenton Hospital,*** 328 NLRB 879 (1999).

B. Classifications Disputed as Technical

I will first address the petitioned-for employees whom the Employer asserts should not be included in a unit of non-professionals because they are technical employees.

"Technical employees are those who do not meet the strict requirements of the term 'professional employee' as defined in the Act but whose work is of a technical nature involving the use of independent judgment and requiring the exercise of specialized training usually acquired in colleges or technical schools or through special courses." ***Rhode Island Hospital***, 313 NLRB 343, 353 (1993) (some internal quotation marks and citations omitted). Technical status is frequently evidenced by the fact that the employee is certified (usually by a national examination), licensed or registered with state authorities, although employees may meet the standards of a technical employee without such certification. *Id*. at 353 (citing ***Barnert Memorial Hospital Center***, 217 NLRB 775, 776 (1975)). Healthcare technical jobs require significant education or training beyond high school, which can be obtained by completing an associate degree from a community college, a vocational training program run by a hospital, a course of studies at an accredited technology school, and in some fields, by completing a 4-year

college degree. *53 Fed. Reg.* at 33918-19, 284 NLRB at 1554. Technical employees generally earn more than other nonprofessionals in the healthcare industry. *Id.*

(1) Anesthesia Techs (ATs)

Four full-time and one contingent ATs work in the anesthesia department which is overseen by Director of Operations Tim Vargas. They are part of the anesthesia care team along with anesthesiologist physicians and certified registered nurse anesthetists (CRNAs). Since about September 2014, the Employer has subcontracted its anesthesia services to Great Lakes Practice Solutions Anesthesia (GLPSA). GPSLA Vice President Michelle Balancio is in charge of hiring and training ATs for the Employer. The parties agree that the ATs are employees of the Employer. While the record evidence demonstrates that Balancio manages the ATs as well as the CRNAs, the AT job description dated December 1, 2015, notes that the ATs report to the Employer Manager of Patient Care Services (Surgical Services). The record does not further address direct reporting relationships.

The AT job description notes essential functions and responsibilities of the ATs as readying operating rooms (ORs) for surgery including cleaning and sanitizing the ORs, discarding used disposable supplies; restocking anesthesia carts; ordering supplies; preparing IVs; patient monitoring procedures; communicating with CRNAs and physicians to facilitate patient needs; assisting with regional anesthesia procedures; and calibrating and troubleshooting anesthesia machines in collaboration with the workroom coordinator, clinical engineering, and chief of anesthesia services.

Required qualifications for ATs are noted on their job description as high school diploma/GED; one-year prior hospital-related work; and basic life support (BLS) certification from the American Heart Association (AHA). Preferred qualifications include current certification through the American Association of Nurse Anesthesia Technicians, or within 6 months of hire. The record does not address the qualifications held by the current ATs.

There is limited record evidence as to the actual duties performed by the ATs regarding their involvement in anesthesia procedures. The record notes that ATs are trained and assessed during a two-month orientation period regarding performance of anesthesia procedures and there is a standardized list used to check-off and test tasks and procedures at the end of their orientation training period. However, no such list was introduced into the record. Balancio testified that the ATs are required to undergo specialized training and possess specialized knowledge in the areas of basic anatomy and physiology, BLS, gases, pharmaceuticals, blood products, infection control, and anesthesia machines. BLS training consists of a one-day course sponsored by the AHA resulting in BLS certification renewable every two years. New-hire ATs also receive a basic one-day training at the hospital on anesthesia machines conducted by a representative from General Electric (GE), the manufacturer of the Employer's anesthesia equipment. As new anesthesia equipment is introduced, ATs receive additional training by GE.

The Employer asserts that ATs' work involves the use independent judgment during surgical procedures. In this regard, they are required to think critically and have keen sense of situational awareness to react to events such as a patient coding. On the other hand, the

Petitioner argues that the ATs' job training and knowledge are limited and no license or certification is required to work as an AT.

Based on the record evidence as a whole, I am inclined to find that the ATs are not technical employees as asserted by the Employer based on their lack of advanced education and technical skills involved in their work. However, since the evidence is insufficient to make a reasoned determination of the appropriate unit placement of the ATs, they shall be permitted to vote subject to challenge in the non-professional unit herein, and their voting eligibility will be determined, if necessary, in post-election proceedings.

(2) Cardiographic Techs (CTs)

Six CTs work in the cardiology department and report directly to Cardiology Supervisor John Silveri who reports to Vice President of Patient Care Services Julia Libcke. The CT job description notes essential functions and responsibilities of the CTs as performing routine patient procedures including in-patient, out-patient and stat EKGs and vital signs; data entry; assisting with clerical functions including chart preparation, answering phones, and scheduling appointments; performing quality assurance testing on equipment; stocking and cleaning EKG carts; transmitting EKG graphs/reports and notifying leadership of unresolved issues; and performing Holter Monitor testing if appropriately trained.

Required qualifications for CTs are noted on their job description as high school diploma/GED; one to two years post-high school education or training in a cardiovascular technologist, paramedic or medical assistant program; BLS-certified with certification kept up-to-date; and CT certification within one year of hire. There is a six to 12-month cardiovascular technologist program available at nearby Carnegie Institute. Five current CTs are certified CTs and one is a recent hire.

The CTs primarily perform routine physician-ordered electrocardiogram (EKG or ECG) diagnostic tests on patients to measure heart rhythms and check for various heart conditions and/or complications. To perform an EKG, the CT assesses and preps the patient's skin and applies stickers in routine places on the chest, arms and legs; attaches EKG leads to the stickers; and turns on the machine. The machine measures cardiac waves in the heart to capture abnormalities such as arrythmias. At the conclusion of the test, the machine automatically generates and transmits the EKG report to the patient's electronic medical record (EMR) on file. The CTs also perform "stat," or emergency, EKGs for patients in distress to check for complications such as a possible myocardial infarction, also known as a heart attack. The CTs are scheduled at the hospital around-the-clock.

CTs are trained to read EKG reports and can spot abnormalities or changes from previous EKG tests which they report to a nurse or physician. They do not consult with patients regarding findings or cardiac care. All final EKG reports are read by a cardiologist. Patients for whom EKGs are ordered may also be ordered by their physician to undergo a heart ultrasound test also known as an echocardiogram. Echocardiograms are performed by cardiac sonographers who take pictures of the heart looking at detailed gradients and abnormalities. As stated, the parties

agree that the cardiac sonographers are not non-professional employees and should be excluded from any unit found to be appropriate herein.

To a lesser degree, the CTs assist exercise physiologists, who are trained in stress testing and cardiac rehab for cardiac patients who have undergone cardiac surgeries and/or procedures, with pre-procedure-intake assessment for stress tests. The stress tests assessments include reviewing cardiology history with the patient, and assisting in the emergency department (ED or ER) with quality assessment by reviewing and training AFCSME-represented PCAs who perform EKGs in the ED. The parties agree that exercise physiologists, who are required to possess a bachelor of science degree, are not non-professional employees and should be excluded from any unit found to be appropriate herein.

The Employer asserts that the CTs herein function at a higher level of expertise than a typical "EKG tech" found in any other hospital, based primarily on their specialized knowledge and performance of duties relating to non-EKG procedures such as their involvement in assisting the exercise physiologists in stress testing, and assisting the ED in quality assessment review of EKGs performed by PCAs in the ED. The Employer additionally argues that the CTs' specialized knowledge related to EKGs including being able to read the diagnostic tests to spot abnormalities or changes demonstrates a high degree of independent judgment required for the CT job.

Although the CT position requires certification within one year of hire, the CT's duties herein primarily include performance of a routine procedure in which the operator does not analyze the test results or use any significant level of independent judgment. ***Southern Maryland Hospital Center, Inc.*** 274 NLRB 1470, 1473 (1985), citing ***Barnert Memorial Hospital Center***, supra at 777 (1975); ***St. Elizabeth's Hospital***, 220 NLRB 325, 327 (1975). Their work duties are akin to the position of EKG tech which has traditionally been found by the Board to be non-technical in nature. ***Southern Maryland Hospital Center, Inc.*** supra at 1473-1475; ***Barnert Memorial Hospital Center***, supra at 777; ***St. Elizabeth's Hospital***, supra at 327; ***Trinity Memorial Hospital of Cudahy***, 219 NLRB 215, 218 (1975); ***William W. Backus Hospital***, 220 NLRB 414, 417 (1975). I conclude that the CTs are not technical employees and should be included in the non-professional unit herein.

(3) Critical Care Techs (CCTs)

Eleven CCTs work in the ICU department and directly report to Clinical Nurse Manager for the ICU Matt Cuddeback. The ICU department is part of Patient Care Services headed by Libcke. The record demonstrates that Cuddeback is a supervisor within the meaning of Section 2(11) of the Act based his authority to hire CCTs.

The CCT job description notes essential functions and responsibilities of the CCTs as working under the supervision of the RNs, assisting them in the implementation of the patient care plan, and completing RN-assigned procedures accurately and promptly; and assisting patients in daily living activities.

Required qualifications for CCTs are noted on their job description as high school diploma/GED; BLS certification; and one of the following: patient care technician education and/or certification from an accredited program with preference to those with prior patient care technician experience; completion of a nursing fundamentals program with preference to those currently enrolled in a nursing program; or emergency medical technician (EMT) license. The patient care technician certification course lasts three months while the EMT program lasts about six months. The record demonstrates that none of the CCTs currently employed possess any degree in nursing while some of them are licensed EMTs.

As noted by their job description, the CCTs primarily complete tasks assigned by RNs such as setting up the ICU room for an incoming patient, obtaining vital signs, starting IVs and arterial lines for blood draws, naso-gastric tube insertion, catheter placement, administering enemas, collecting urine and stool specimens, emptying and recording ostomies and drains, obtaining blood from transfusion services, assisting in patient examinations by physicians, transporting patients, and completing post-mortem care. In assessing and caring for patients, they are to notify a RN of any changes in patient medical status.

New CCTs are trained on-the-job for approximately four to six weeks by a nurse preceptor. A preceptor is a more experienced employee in the same department or position. Throughout the orientation training period, the CCTs and evaluating nurse preceptors complete daily competency evaluations in the areas of clinical knowledge and procedures, equipment, hygiene, infection control, nutrition, technical skills, critical thinking, communication, professionalism, and management of responsibilities. It is noteworthy that with regard to "technical" skills, the CCTs are assessed in the daily competency evaluations only concerning "compliance with documentation requirements." The nurse preceptor also completes a checklist evaluating the CCTs in the areas of communication/interpersonal skills, and pre-op/post-op patient care.

The Employer asserts that performance of the above duties requires the CCTs to use critical thinking and independent judgment regarding independently transitioning the patient from the OR to the ICU, setting up the patient's room, assessing patient status, and performing patient care procedures. However, the weight of the record evidence reveals that the CCTs exercise little, if any, discretion in performing their duties. Rather, they work under the close and constant supervision of a RN at all times.

Although their job description requires education and/or certification from an accredited program, the record demonstrates that none of the CCTs currently employed possess any such certification or degree in nursing besides an unknown number who are EMT-licensed. There is no record evidence that those who possess EMT licenses use such EMT skills in the performance of their CCT duties. Overall, the duties of the CCTs are more akin to nursing assistants who are traditionally included in a non-professional unit. See ***Rhode Island Hospital,*** supra at 357 (1993)(medical practice technician, responsible for vitals, specimen collection, blood samples, injecting medicines and other venipuncture activities, found appropriately within the nonprofessional unit). I conclude that the CCTs are not technical employees and should be included in the non-professional unit.

(4) Endoscopy Techs (ETs)

Four ETs work in the endoscopy area of the perianesthesia care unit (PACU) which is overseen by PACU assistant clinical manager Asia Viers. The PACU department is part of Patient Care Services headed by Libcke.

The ET job description notes essential functions and responsibilities of the ETs as ensuring endoscopy rooms are clean, sanitized and stocked with supplies; performing safety checks on, maintaining and repairing endoscopic equipment; transporting patients; assisting during endoscopy procedures including collecting patient specimens; and performing clerical duties such as ordering supplies and patient data entry.

Required qualifications for ETs are noted on their job description as high school diploma/GED; three months' clinical experience and/or training in ancillary department; and BLS certification. Preferred qualifications include ET certification by Society of Gastroenterology Nurses and Associates (SGNA); and one-year experience in a comparable medical setting. The record does not demonstrate that any of the current ETs possess SGNA certification.

Viers testified that the Employer's job description listing essential functions and responsibilities accurately describes the ETs actual job duties. There is record evidence that the ETs require advanced knowledge regarding clinical endoscopic procedures and equipment. In this regard, they administer IVs for endoscopic procedures and assist physicians with endoscopic equipment during endoscopic procedures. Two of the four current ETs were already trained in IV administration at the time of their hire, and the other two ETs are currently in the process of being IV-trained.

With regard to duties related to assisting physicians with endoscopic equipment during endoscopic procedures, the ET position appears to be similar to the role of a surgical/OR tech who assists physicians in the OR by holding instruments and handing supplies and instruments to the operating physician. Traditionally, the Board has included surgery technicians in technical units based on their specialized training and application of their training to the performance of their duties. ***Rhode Island Hospital,*** supra at 354; ***Meriter Hospital, Inc.***, 306 NLRB 598, 600-601 (1992); ***William W. Backus Hospital***, supra at 418. However, unlike typical surgical/OR techs, the ETs have no qualifications requirements of advanced knowledge or certification. They are merely required to possess a high school diploma/GED and three months' clinical experience. In assessing the duties and qualifications of the ETs, I find there is limited record evidence to make a determination as to whether they should be included in the petitioned-for unit of non-professional employees or excluded as technical employees. I conclude that since the evidence is insufficient to make a reasoned determination of the appropriate unit placement of the ETs, they shall be permitted to vote subject to challenge in the non-professional unit herein, and their voting eligibility will be determined, if necessary, in post-election proceedings.

(5) Perioperative Techs (PeTs)

Seven PeTs work in the PACU overseen by Viers. They are scheduled to work Monday through Friday from 6:00 a.m. to 6:00 p.m., and on the weekends from 6:00 a.m. to 2:00 p.m.

The PeT job description notes essential functions and responsibilities of the PeTs as assisting RNs in pre-op and post-op phases including monitoring flow of OR boardings; reviewing patient charts to order, retrieve and input test results; collecting patient specimens per requested orders; starting IVs on patients 12 years or older; transporting patients; ensuring operating rooms are stocked with supplies; and assisting in orientation of new personnel.

Required qualifications for PeTs are noted on their job description as high school diploma/GED; six-months' direct patient care experience in an acute care setting; and BLS certification. Preferred qualifications include one-year direct patient care experience in an acute care setting, skills in phlebotomy, IV insertion, EKG administration; and medical terminology knowledge.

Viers testified that the Employer's job description listing essential functions and responsibilities accurately describes the PeTs actual job duties. There is record evidence that the PeTs work largely under the direction of the OR nurses. They are tasked to perform pre-op duties which include taking vitals, IV placement, blood draws, EKGs, and shaving for surgery. The OR nurse must verify that PeT tasks are performed adequately before the patient is transferred to the OR. If a PeT encounters problems with any pre-op duties such as with starting an IV or doing a blood draw, the OR nurse immediately steps in. Post-op patient care by PeTs includes monitoring vitals and transporting patients following surgery. The PeTs are trained on-the-job in all of these tasks for a minimum of six weeks by a nurse preceptor. At the end of the orientation training period, the preceptor completes an evaluation for the PeT which includes a checklist in the areas of communication/interpersonal skills, and pre-op/post-op patient care.

The PeTs have no qualifications requirements of certification, licensure, or advanced knowledge. The only educational requirement for this job is a high school diploma/GED. Like the CCTs, they work largely under direction of a nurse and their duties are more akin to nursing assistants who are traditionally included in a non-professional unit. I conclude that the PeTs are not technical employees and should be included in the non-professional unit.

(6) Pharmacy Tech-1s, Pharmacy Tech-2s (PhTs)

Four PhT-1s and fourteen PhT-2s work in the pharmacy department and directly report to lead pharmacist Allan Miller. Miller apparently reports to the Pharmacy Director; however, the record does not identify who that is. It appears from the record evidence that Miller is a supervisor within the meaning of Section 2(11) of the Act based on his direction of work of the PhTs as described below.

There is one PhT job description for PhT-1 and PhT-2 which notes essential functions and responsibilities of all PhTs as processing pharmacy orders; assisting pharmacists in filling

containers, preparing and affixing labels, prepackaging pharmaceuticals, maintaining records and stocking supplies; assisting in ordering, receiving, inspecting and adjusting stock; maintaining crash carts and nursing station inspection reports; performing pharmacy computer functions including recordkeeping, billing and accounting; and assisting in training pharmacy personnel. The job description lists additional functions and responsibilities of the PhT-2s as "special tasks, responsibilities and projects as directed."

Required qualifications for PhT-1s are noted on the PhT job description as high school diploma/GED; and a state-issued temporary, limited or full PhT license. Required qualifications for PhT 2-s are the same as for PhT-1s, plus two-years PhT experience. Preferred qualifications for PhT-1 and PhT-2 include computer experience; and previous pharmacy courses or experience. Licensing is available to the PhTs from the State of Michigan including a temporary license can be converted to a full license by completion of state licensing requirements within 365 days of hire. The Employer has also grandfathered in PhTs who possess "limited" licenses received prior to 2017, when current state licensure rules went into effect. PhT certification is available from the Pharmacy Tech Certification Board (PTCB). PTCB certification requires completion of 60-hours of community college course work and successful completion of a final certification exam. The record is unclear as to whether the PTCB certification exam includes a math assessment, as asserted by the Employer, or merely consists of a standard background check, as asserted by Petitioner.

The PhTs primarily compound and package medications ordered by physicians. In this regard, the physician transmits the prescription to a pharmacist who is educated and trained to fill and dispense the prescription with the accurate amount of medication to the patient. Under the direction of a pharmacist, the PhT creates a label for the prescription and compounds the medication by placing the medication in the container. By the time the medication reaches the PhT for compounding, all dosing levels have been pre-determined by the pharmacist. The PhT has no authority to change the pre-determined dosing and label in any respect. If the PhT suspects there is a label error then the label is returned to the pharmacist for further review. After compounding the medication, the PhT returns the prescription medication to the pharmacist who checks it for accuracy and signs off on it. The medication is then dispensed to the patient.

New PhTs participate in a six-week orientation training program which includes two rotation of one to two weeks each in unit dose training and float training. Unit dose training includes the handling of oral meds and float training includes the handling of IV meds, use of IV room and the automatic med dispensing cabinet. The record is silent as to who provides this orientation training to the PhTs.

The Employer asserts that the PhTs are technical employees based on their use of independent judgment in creating and assessing labels, and compounding and packaging medications. The Employer argues that the PhTs are trained to assess a label and notify the pharmacist if any label error is suspected. In compounding and packaging medications the Employer contends that the PhTs can take different routes for compounding medications to achieve the final formula that is dispensed to the patient. This might include using a certain IV bag to compound and package IV meds or using math skills to convert different concentrations

of meds. However, the record demonstrates that the PhTs cannot vary from the label dictated and pre-determined by the pharmacist and Employer safeguards ensure that the label will not scan properly if the PhT does not use specific concentrations and follow pre-determined labels. While the PhT might use basic proportional math skills in measuring meds, he/she does not ever change pre-determined med concentrations.

The Board has considered the status of pharmacy techs in several cases. In ***Rhode Island Hospital***, supra at 356, the Board found that the pharmacy techs therein were not technical employees where, as in the instant case, they assisted the pharmacist in the preparation, dispensing and delivery of medications. In that case, the pharmacy techs were required to have either one or two years of college or comparable work experience and, in addition, were required to complete a 15-week in-house training course. Id. at 356. In ***Meriter Hospital, Inc.***, supra at 601, pharmacy techs therein were likewise excluded from a technical unit, where, as in the present case, they prepared IV mixtures, processed prescriptions, and kept inventory. See also, ***Southern Maryland Hospital Center, Inc.***, supra at 1474.

On the other hand, in ***Duke University***, 226 NLRB 470, 472 (1976), the Board found the pharmacy techs to be technical employees. In that case, the pharmacy techs had to complete a six-month certification course and have on the job training. It appears, however, that the successful completion of a pharmacy tech training program alone does not, based upon recent Board decisions, compel or warrant the conclusion that pharmacy techs are technical employees when their job duties primarily include filling prescriptions and mixing IV solutions under the constant supervision and close scrutiny of the pharmacists. ***Rhode Island Hospital,*** supra at 356; ***Meriter Hospital, Inc.***, supra at 601.

As in the ***Rhode Island Hospital, Meriter Hospital,*** and ***Southern Maryland Hospital*** cases, the PhTs herein similarly work in close association with and under the direct supervision of the pharmacist, who checks all of their work. When they fill the prescriptions or prepare IV solutions, their work is reviewed by the pharmacist. While the PhTs watch for errors which they then report to the pharmacists; they have no discretion to take any further action. I conclude that the PhTs are not technical employees and should be included in the non-professional unit.

(7) Lab Assistants (LAs)

Forty-four (44) LAs, formerly known as lab phlebotomists and lab pathology aides, work under the direction of Lab Manager Todd Wolney who oversees all lab operations for the Employer. While the LA job description further notes that the LAs work under the direct supervision of a Lab Supervisor, Clinical Lab Technologists, Cytotechnologists or other designated lab personnel, the record does not address such direct reporting relationships.

The LA job description is lengthy in listing essential functions and responsibilities. The position summary contained therein notes that,

> "[LA] performs all specimen collection by phlebotomy for the correct individual at in-house or off-site locations. In addition, obtains other specimens when indicated, and instructs patient in the collection of specimens as necessary. May be required to enter Pathology specimens into various computerized information system along with the preparation and staining of Cytology specimens…".

Required qualifications for LAs are noted on their job description as high school diploma/GED; valid driver's license; and certification as a phlebotomy tech or medical assistant (MA), or a minimum of six-months prior work experience drawing blood. Preferred qualifications include one year of blood drawing experience and completion of an accredited phlebotomy program or MA school; or six months prior phlebotomy or MA experience. A large majority of the Employer's LAs are certified phlebotomy techs.

Thirty-four (34) LAs work as in-patient phlebotomists in the lab administration department of the hospital and are assigned to do blood draws for patients staying in the hospital. They also rotate for some patients living off-site among some nursing homes and other senior living facilities. Eight LAs work as out-patient phlebotomists rotate in the out-patient lab department of the hospital, called the "reference lab," as well as five off-site blood draw stations. Two LAs, Heather Stocchi and Lia Derr, work as lab pathology aides in the pathology department of the hospital.

In performing blood draws, the LA phlebotomists follow specific lab orders issued by physicians as well as specific protocols and procedures for patient care related to blood draws. Drawing blood involves prepping the patient's skin, locating the poke site, using needles for insertion, using pre-determined color-coded tubes to use for collection, and transmitting tubed blood for processing through the Employer's computer and tube system. The computer system for the lab is called Laboratory Information System (LIS). The LAs in the pathology department work under the direction of a cytotechnologist and primarily assist in processing tissue and specimens from OR patients. Like the other LAs, they are required to be certified in phlebotomy and in this regard they assist in the reference lab as needed. There is some limited record evidence that some of the LAs are on-call for emergency "stat" and "code" blood draws, and some of them process orders for specialized tests incorporating previous blood draws.

The Employer asserts that the LA phlebotomists use independent judgment in performing blood draw duties by assessing and choosing skin site to poke, choosing which needle to use, following the tube protocol, and labeling drawn specimens. Additionally, the Employer asserts that the lab pathology aides' specialized training and skill set affords them the status of technical employees.

The LAs herein perform work in similar nature to phlebotomists who have traditionally been found by the Board to be non-professional rather than technical employees. See ***St. Vincent Charity Medical Center,*** 357 NLRB 854, 855-857 (2011); ***Southern Maryland Hospital Center, Inc.,*** supra at 1474-1475. The LAs are not required to have any specialized training or certifications, other than as a phlebotomist. They perform routine collection and processing of blood and specimens from patients pursuant to well-established protocols and under the supervision of a supervisor and lab manager, and exercise minimal

independent judgment in the process. Their pay rates are comparable to those of other employees included in the non-professional unit herein. There is no evidence in the record that the LAs who work in pathology are required to have any additional education or certification in comparison to the LAs who work in the in-patient and out-patient labs.

In reaching this conclusion I have carefully considered the Employer's arguments but do not find them persuasive. In ***Trinity Memorial Hospital of Cudahy,*** supra at 217-218, relied on by the Employer, the Board found that laboratory technicians and laboratory aides working in the pathology department were technical employees based on their specialized training (laboratory technicians completed a 2-year pathology program at a technical college or institute, and laboratory aides completed a year of post high school in-service scientific training). and exercise of "interpretive responsibilities." In ***Faribault Clinic***, 308 NLRB 131, 132 (1992), relied on by the Employer, the Board, in finding laboratory technicians to be properly included in a technical employee unit, found they were required to have "substantial advanced education and certification." No such factors are present in the present case.

Accordingly, I conclude that the LAs are not technical employees and should be included in the non-professional unit herein. See ***William W. Backus Hospital,*** supra at 417 (1975); ***Clarion Osteopathic Community Hospital,*** 219 NLRB 248, 249 (1975); ***Southern Maryland Hospital,*** supra at 1474-1475.

C. Classifications Disputed as Non-Professional

I will next address employee classifications which are not included in Petitioner's petition and Employer asserts must be included in the petitioned-for unit as non-professional employees.

(1) Academic Program Administrator-1s (APA-1s), Academic Program Administrator-2s (APA-2s), and Graduate Medical Education Specialists (GMESs)

One APA-1 and five APA-2s work in the medical education department and report to Director of Medical Education Pamela Royston who reports to Vice President of Medical Affairs Dr. Andrew Staricco in the medical affairs department. Royston also oversees the Graduate Medical Education (GME) Manager and the GMES discussed below.

The APA-1 job description notes essential functions and responsibilities of the APA-1s as performing functions in academic programs such as assisting with program development, tracking, implementing, evaluating, providing and maintaining medical student/resident services for medical education; preparing and submitting documentation for medical education and accreditation services; maintaining knowledge regarding the Accreditation Council for GME (ACGME) and program requirements, procedure and policies to support the GME program; acting as a liaison to educational consortia; negotiating with other institutions to secure educational experiences for medical students/residents; corresponding with medical students/residents regarding matching program and onboarding with Employer's human resources department; and providing financial oversight of program budget in partnership with department leaders. The APA-2 job description is not remarkably different from the APA-1 job description regarding essential functions and responsibilities.

Required qualifications for APA-1s are noted on their job description as associate degree in health care administration, business or related field; or a combination of one year of education and one year of related field experience. Preferred qualifications include a bachelor's degree in health care administration, business or related field; and experience in healthcare setting and medical education. Required qualifications for APA-2s are noted on their job description as associate degree in health care administration, business or related field, plus certification by the Training Administrators of Graduate Medical Education (TAGME); high school diploma with two-years medical education experience and certification by TAGME.

There is one current APA-1 who possesses only a high school diploma and is a long-time employee. The record demonstrates that TAGME certification requirements and other accreditation changes that went into effect in about Fall 2018, would have disqualified this employee as an APA. Thus, around this time the Employer created separate APA-1 and APA-2 positions in line with TAGME's efforts to move APAs into greater leadership roles within residency programs. All of the current APA-2s possess bachelor's degrees; one is TAGME-certified; two are becoming TAGME-certified; and two are new hires who will be eligible for TAGME certification after two years of employment as an APA-2.

There is limited record evidence as to the actual duties performed by the APAs. The record evidence reveals that they are the first contact person for a medical student/resident joining hospital staff and they act as a liaison between the medical student/resident and the Employer. While the record reveals that the residency program is managed by an Employer physician who is the Program Director, it not identify by name or describe the role of the Program Director. The record does indicate that there is little difference in the work performed by the APA-1s versus the APA-2s. There was some conclusory evidence that the APA2-s work more independently and have more outside contact with the ACGME regarding accreditation duties, however, such duties were not addressed.

Petitioner argues that the APAs are either professional or technical employees. Both APA positions appear to require some advanced education and knowledge regarding medical education and accreditation standards for different specialties possessed by the residents. Petitioner argues that both APA positions are beyond clerical in nature, involve a leadership role in education and are either professional or technical. However, the Employer argues these duties do not involve any exercise of independent judgment because guidelines provided by ACGME dictate decisions made by the APAs.

There is one Graduate Medical Education Specialist (GMES) who works in the Employer's medical education department and reports to a GME manager (who was not named in the record). That GME manager then reports to Director of Medical Education Pamela Royston who also oversees the six APAs discussed above.

The GMES job description notes essential functions and responsibilities of the GMESs as applying curricular residency requirements including requests for rotations with attending physicians; assisting residents with rotation requests; creating resident schedules including outside rotations with affiliated training hospitals; appraising the placement of all levels of

physician trainees; assisting in resident-related departmental functions and events; maintaining complete academic files on all physician trainees; and communicating with prospective trainees.

Required qualifications for GMESs are noted on their job description as a high school diploma/GED; and three-years prior office experience. Preferred qualifications include prior related experience in GME; a bachelor's degree; and five-years prior office/GME experience.

The Employer hosts medical students for rotations per affiliation agreements in place between it and various medical schools. The medical students perform four-week rotations at the hospital throughout each year. There are 13 rotations scheduled per year. A majority of these medical students come from Michigan State University. The GMESs primarily act as a liaison between the Employer and the medical school to schedule rotations for medical students. Their scheduling activities are performed independently and are not subject to approval. At the end of each rotation period, the GMESs collect student evaluations completed by the Employer and transmit them to the medical school. There is no record evidence that the GMESs participate in any way in these student evaluations. The GMESs also have some responsibilities in scheduling meetings and education sessions for resident physicians employed at the hospital. While the record evidence demonstrates that the GMESs also perform some duties related to the operation of the accreditation system, the record is silent as to any specific duties performed in this regard. The GMESs participate in a one-year on-the-job apprenticeship training period to learn their job duties.

Petitioner argues that the GMESs may be professional employees based on their qualifications and significant financial responsibilities including paying physicians and processing exam payments and defending Employer charges in Medicare/Medicaid audits. However, the record does not support the GMESs' actual involvement in such duties and responsibilities. Petitioner additionally argues, on the opposite end of the spectrum, that the GMESs may be business office-clerical (BOC) employees.

Professional employees within the meaning of Section 2(12) of the Act include those whose work is predominantly intellectual and varied, involves the consistent exercise of discretion and judgment, cannot be standardized in relation to a given period of time, and requires specialized knowledge of an advanced type. ***Samaritan Health Services, Inc.***, 238 NLRB 629, 636 (1978) citing ***Sutter Community Hospitals of Sacramento, Inc.***, 227 NLRB 181, 186 (1976). BOC employees traditionally perform functions such as handling finances and billing, dealing with Medicare/Medicaid, and other reimbursement systems. They are generally supervised separately in business office clerical departments; this separation has resulted from the almost universal centralization of business office functions. Business office clericals have little interaction with other nonprofessionals as the business office clerical offices are often physically isolated. See ***Lincoln Park Nursing & Convalescent Home, Inc.***, 318 NLRB 1160, 1164 (1995), citing ***Rhode Island***, supra at 359.

In assessing the duties and qualifications of the APAs and GMESs, I find there is limited record evidence to make a determination as to whether they should be included in the petitioned-for unit of non-professional employees. I conclude that since the evidence is insufficient to make a reasoned determination of the appropriate unit placement of the APAs, they shall be permitted

to vote subject to challenge in the non-professional unit herein, and their voting eligibility will be determined, if necessary, in post-election proceedings.

(2) Medical Staff Services Coordinators (MSCs)

One MSC works in the medical affairs department and reports directly to Chief Medical Officer/Vice President of Medical Affairs Dr. Andrew Staricco. Staricco also supervises managers and directors in the medical affairs department. However, the record is silent as to the identification and roles of such managers and directors.

The MSC job description notes the position summary as "coordinates processing of applications, appointments, and administrative support services for medical staff and health professionals." Essential functions and responsibilities include handling billing, collection and deposit of medical staff dues; scheduling, coordinating and attending all assigned medical credential-related department meetings, conferences and events; handling internal and external verification requests regarding credentialing for hospital privileges, residencies and fellowships; ensuring data integrity regarding up-to-date licenses, malpractice coverage and certifications for all employees with memberships and/or privileges; partnering with physicians and providing monthly progress reports regarding new physician performance; ensuring medical staff accreditation compliance; ensuring data security and confidentiality; and maintaining professional and technical knowledge.

Required qualifications for MSCs are noted on their job description as an associate degree in business administration, health services administration or related field; three years of medical staff credentialing experience; and certification obtained within 12 months in medical services management by National Association Medical Staff Services (NAMSS), or as a credentialing specialist. Preferred qualifications include a bachelor's degree in business. The current MSC, Darlene Graham, possesses an associate degree.

Current MSC Graham works with recently-employed medical staff credentialing specialist (MSCS) Laurie Crossman[8] to ensure that physicians and clinicians seeking hospital privileges are properly credentialed. This includes verifying the applicant's level of experience and training; performing a criminal background check on the applicant; and communicating with outside institutions in which the applicant has practiced or had privileges. Graham and the then-MSCS recently participated in the new-hire interview of Crossman and recommended her hiring to Staricco. The record demonstrates that Staricco considered their recommendations but made the final decision on his own. As stated, the parties agree that medical staff credentialing specialists should be excluded from a non-professional unit.

The Petitioner argues in its brief that the position of MSC is either professional, based on qualifications, or BOC, based duties and lack of involvement with direct patient care. During the hearing, Petitioner additionally asserted that the MCSs possess supervisory authority within the meaning of Section 2(11) to direct the work and to discipline or recommend discipline of MSCSs. The Employer argues that the MSC job does not involve any use independent judgment in that MSC's merely make routine decisions regarding applicant credentials.

[8] A second CS retired effective July 3, 2019.

In assessing the duties and qualifications of the MSCs, I find there is limited record evidence to make a determination as to whether they should be included in the petitioned-for unit as non-professional employees. I conclude that since the evidence is insufficient to make a reasoned determination of the appropriate unit placement of the MSCs, they shall be permitted to vote subject to challenge in the non-professional unit herein, and their voting eligibility will be determined, if necessary, in post-election proceedings.

(3) Administrative Assistants (AdAs)

Two AdAs work for the Employer. One AdA in the cardiology department, which is within the patient care services department, reports directly to Cardiovascular Service Director Stacey McDougal. McDougal then reports to Vice President of Patient Care Services Libcke. Another AdA works in the case management department in the hospital, which is within the finance department/CBO and reports directly to Case Management Supervisor Mary Baker, who in turn reports to Interim Director of Case Management Todd Adams.

The AdA job description notes essential functions and responsibilities of the AdA as performing general office duties including filing, scanning, copying, faxing, and answering phones; creating, maintaining and updating files and internal reports; scheduling and attending meetings and preparing minutes; ordering office supplies; and responsibility for timekeeping functions of the department.

Required qualifications for AdAs are noted on their job description as high school diploma and four years minimum of clerical experience. Preferred qualifications include an associate degree.

The AdA in cardiology works in the cardiology administration suite at the hospital near the office of Director McDougal's office, offices for a number of cardiologists, a cardiology advanced-practice nurse, and some cardiology fellows. This AdA primarily performs general office functions such as scheduling cardiology meetings for the cardiology department and preparing meeting agendas and minutes.

The AdA in case management works in the case management office area outside of Supervisor Baker's office. Offices for case managers, social workers and utilization review nurses are also located in this area. This AdA has duties primarily related to payroll, scheduling, and data entry for the case management department. Regarding payroll duties, this AdA has special access to the employee Kronos payroll system and assists Baker in verifying hours worked by department employees but does not provide assessment or possess any authority with regard to payroll matters. Regarding scheduling duties, this AdA creates eight-week schedules for full-time, part-time and contingent department employees. Neither of the AdAs is involved in direct patient care.

The Petitioner argues that the AdAs are either professional employees, based on their educational qualifications and extensive involvement in the Employer's financial systems as well as the exercise of independent judgment in their scheduling duties, or BOC employees, based on

their close relation to the finance/CBO department. The Employer argues that the AdAs should be included as non-professionals in the unit based on their community of interest with the clerical associate 2-s[9] whom the parties agree are properly included.

The record does not demonstrate that the AdAs possess any specialized knowledge of an advanced type to deem them professional employees within the meaning of Section 2(12) of the Act. ***Samaritan Health Services, Inc.***, supra at 636. Neither do they fall into the category of BOC. Although the AdAs in the case management department fall under the wing of the finance department/CBO, the Employer's CBO is located off-site at the Glass House and includes employees employed as accountants, financial analysts, payroll employees, financial clearance employees, HR employees, *and business-office clerical employees*, whom the parties agree are not at issue herein. Here, the AdAs work in hospital offices among non-professional employees whom the parties agree should be included in the unit and do not perform traditional BOC work. See, ***Lincoln Park***, supra at 1165 (nursing home receptionists found to be non-professionals and not BOCs in a unit including employees involved in direct patient care and non-patient care, where they were not involved in direct patient care and worked in areas of the facilities near the main lobbies not physically isolated in the BOC offices). As such, I conclude that the AdAs[10] should be included in the petitioned-for unit of non-professional employees.

(4) Audit analysts (AA) and Billing Clerks (BCs)

One AA works in the surgical services department and reports to an OR manager, not identified in the record, who reports to Director of Surgical Services Linda Witt. Witt oversees all of the Employer's surgical departments including approximately 200 employees employed as RNs, surgical techs, ETs, CSR central reprocessing techs, point-of-service clerks,[11] and clericals.

The AA job description notes essential functions and responsibilities of the AAs as reviewing medical documentation and adjusting patient charges; reporting to surgical services management staff and patient financial services department regarding documentation and billing issues; assigning and creating medical codes for surgical services; auditing surgical services charges; and data entry into patient medical record.

---

[9] There are three clerical associate-2s that work in the case management department who primarily perform clerical duties for the case management department including answering phones, receiving faxes and calls from insurance companies, and relaying information to case managers and social workers. They also sometimes go to the nursing units for patient chart information. The parties stipulated that the clerical associate-2s are non-professional employees and should be included in any unit found appropriate herein. One of these clerical associate-2s works on the 5th floor of the hospital along with two case managers and a social worker, and the other two clerical associate-2s work on the first floor of the hospital. There is no record evidence showing that any clerical associates work in the cardiology department.

[10] In making this finding I note that the case management department AdA's special access to the Employer's payroll system is insufficient to confer confidential status where there is no showing that this AdA assists or acts in a confidential capacity to persons who formulate, determine, and effectuate management policies in the field of labor relations. See ***Lincoln Park***, supra at 1164, citing ***B.F. Goodrich Co***., 115 NLRB 722 (1956); B***akersfield Californian***, 316 NLRB 1211 (1995). See also ***Inland Steel Company*** 308 NLRB 868, 877 (1992).

[11] The point-of-service clerks are in the AFSCME bargaining unit.

Required qualifications for AAs are noted on their job description as one to two years post-high school education or training in surgical technology; and five-years work experience in an OR. Preferred qualifications include an associate degree in nursing; two-years prior auditing/billing experience; or current RN licensure. The current AA does not possess a degree in nursing.

Witt testified in a conclusory manner that the job description listing essential functions and responsibilities of AAs accurately describes the AAs' actual job duties. Limited record evidence demonstrates that the current AA primarily reviews patient charts for purposes of entering data into the computer system to charge and audit medical supply and equipment use and services during surgical procedures. In this regard, the AA must be familiar with hospital equipment and supplies which are indexed on a standard list with accompanying codes.

One BC works in the wound care department and reports directly to Director of Patient Care Services Doreen Hayes. Hayes also oversees approximately 350 employees who work in the med surgical department, out-patient department, special care nursery, family birthing center, pediatric area, infusion department, and dialysis department.

The BC job description notes essential functions and responsibilities of the BCs as preparing and verifying bills and invoices for medical services; establishing payment for and communicating with collection agencies regarding delinquent accounts; obtaining medical authorization from insurance companies and logging incoming insurance payments; and monitoring debts and unresolved accounts by filing claims for legal action. Required qualifications for BCs are noted on their job description as high school diploma/GED. Preferred qualifications include medical billing and coding experience.

The current BC works on the first-floor surgical center nursing station. Her primary duties include scheduling patients for wound care, data entry, and filing. The BC uses a computer program called Wound Care Expert to measure patient wounds, assign a code to the wound, and file wound pictures. As with the AAs, are there pre-determined billing codes for wounds.

The Petitioner argues that AA and BC positions are primarily financial in nature and as such they are akin to positions found to be BOC in ***St. Luke's Episcopal Hospital***, 222 NLRB 674, 676 (1976) (Internal audit employees who performed accounting-related functions found to be BOC); ***Seton Medical Center***, 221 NLRB 120, 122 (1975) (audit clerks in the patient account services department found to be BOC based on performance of office-clerical duties related to patient records and no interaction with petitioned-for employees); and ***Trumbull Memorial Hospital***, 218 NLRB 796, 796-797 (1975) (audit clerks who worked in a strict business office capacity found to be BOC).

In ***Trumbull Memorial Hospital***, however, the Board distinguished between certain clerical employees who "work in an essentially 'business office' capacity and…have little in common with…[other] clerical employees who work alongside and with a similar objective as employees involved more immediately with the care of patients." Id at 796. On this basis, the

Board stated it would exclude strict BOCs from a service and maintenance unit while including other types of clericals in such a unit. Id at 796 (other citations omitted).

The AA and BC do not work in the CBO/finance department, they do not interact with CBO employees, and they are not supervised directly by or under the wing of CBO management. Rather, they work in patient care services departments and they share supervision with other non-professional petitioned-for employees. To determine whether the AA and BC would be more appropriately placed in a separate BOC unit would require further examination including a comparison of the factors relied on by the Board in finding a separate BOC unit appropriate including education, training, functions, location, supervision wages, interchange and transfer among others. There is limited record evidence to enable such a comparison, especially concerning the actual job duties and responsibilities of the AA. Thus, the AA and BC shall be permitted to vote subject to challenge in the non-professional unit herein, and their voting eligibility will be determined, if necessary, in post-election proceedings.

(5) Biomedical Tech-1s (BT-1s), Biomedical Tech-2s (BT-2s), Biomedical Tech-3s (BT-3s)

One BT-1, two BT-2s, and three BT-3s work in the clinical engineering department, also known as the biomedical engineering department, and report directly to Manager of Clinical Engineering Scott Scandalito, who reports to Director of Operations/COO Tim Vargas.

The BT-1 job description notes essential functions and responsibilities of the BT-1s as primarily servicing and maintaining medical equipment exercising judgment and technical competence. The BT-2 and BT-3 job descriptions are not remarkably different from the BT-1 job description with regard to essential functions and responsibilities.

The BT-1 job description lists required qualifications as an associate degree in electronics, biomedical engineering or equivalent technical training in repair and maintenance of technical equipment; and knowledge regarding use and operation of software-based products including general PC based systems and database and office software applications. The BT-2 job description notes the same required qualifications as BT-1 with the addition of documented attendance at two or more manufacturer-sponsored model specific equipment service training sessions; ability to work independently with limited supervision; and five or more years of advanced clinical equipment repair and maintenance experience. The BT-3 job description contains the same required qualifications as BT-2 with the addition of certification as a BT; documented attendance at five or more manufacturer-sponsored model specific equipment service training sessions; ability to work independently without supervision; and ten or more years of advanced clinical equipment repair and maintenance experience.

As noted, the BTs primarily repair and maintain all of the hospital's medical equipment, which includes approximately 8,000 machines. The BTs work on these machines in the clinical engineering shop located inside the hospital which includes a large work space, work benches and computers. Scandalito works in an administrative office in the same area. For repairs and maintenance on large equipment that is not portable, the BTs travel throughout the hospital to

where the equipment is located. The BTs work Monday through Friday from 7:00 a.m. to 4:30 p.m., and they are on a 24/7 on-call rotation for all other hours.

The BTs use a variety of tools, from basic to high-tech, to perform repair and maintenance duties such as a socket wrench or hammer to test-equipment tools, electronic safety analyzers, and specialized tools that validate tachometers and other machines. They receive specialized training to use such tools. They must also have an understanding of electronics and medical terminology and be able to read and understand tech/operator manuals that match hospital equipment. They are generally able to consult an operator's manual or troubleshoot by computer to make a repair or resolve an equipment problem. However, as a last resort, when a repair is beyond the knowledge of the BT, or if their work load is particularly heavy, the BT may contact a manufacturer's tech support person or third-party contractor to schedule repairs on hospital equipment and machines. This happens on average about once a week.

The Employer's pre-determined protocols for equipment repair are strict and the BTs are not allowed to venture outside of manufacturer-prescribed repairs. Regarding performance of scheduled maintenance, the BTs follow strict manufacturer-provided schedules which are input into computer systems and generate notifications to the BTs that it is time for maintenance.

There is little difference in the work performed by the BT-1s in contrast to the BT-2s and BT-3s. The primary differences are that the BT-1s are new in the field, work under the leadership of a BT-3, and do not perform as advanced tasks as the BT-2s and BT-3s. For example, a BT-1 might work on repairing a simple infusion pump while a BT-2 or BT-3 might work on a complex ventilator machine. The BT-2s possess approximately two years of experience in the field and perform some autonomous work but continue to work under the leadership of a BT-3, while the BT-3s possess at least 5 years of experience in the field, might be certified, and can work autonomously on the most advanced equipment and machines. The BTs do not require any certification or license to perform their duties. The BTs' wages are at the higher end of the wage scale in comparison to many of the petitioned-for employees.

Other employees, such as anesthesia techs and respiratory equipment techs, also perform some repair and maintenance on hospital machines but perform work that is much less sophisticated and is limited to replacing filters and canisters, cleaning equipment, or recalibrating a machine by pushing a button.

Petitioner argues that the BTs require a high degree of technical competence and that their qualifications and use of highly specialized tools afford them the status of technical or skilled maintenance employees rather than non-professionals. The Employer contends that the work of the BTs is guided by strict manufacturer and industry guidelines and does not require a significant degree of specialized knowledge.

In ***Toledo Hospital***, 312 NLRB 652 (1993), the Board found that the Regional Director erred in excluding biomedical engineering techs from a petitioned-for skilled maintenance unit because they were in a separate department, and had separate supervision, minimal contact and a different pay scale from the other maintenance employees. Relying on ***San Juan Medical Center***, 307 NLRB 117 (1992), the Board determined that these biomedical engineering techs

who performed skilled work on complex, sophisticated machinery must be included in a skilled maintenance unit despite their greater education, higher wages, different hours worked, and minimal interaction and interchange with the other petitioned-for employees who provided maintenance to the hospital's physical plant. Based on the above, I conclude that the BTs are more properly included in a skilled maintenance unit and should not be included in the petitioned-for unit of non-professional employees.

(6) Inventory assistants (IAs) and Inventory coordinators (ICs)

Two IAs and five ICs work in the supply chain/materials management department and report directly to Supervisor Michael Drobek, who reports to Site Manager in Supply Chain Management Dominic Tranchida.[12] The materials management department is a separate department that is under the wing of the finance department. The record demonstrates that Drobek is a supervisor within the meaning of Section 2(11) of the Act based on his authority to hire, fire and discipline employees.

The IA job description notes essential functions and responsibilities of the IAs as reviewing stock locations and recommending supply needs to buyer; performing cycle counts and investigating and correct variances; monitoring and ordering warehouse items; stock intake; cleaning and organizing stock locations; and participating in annual inventories.

Required qualifications for IAs are noted on their job description as a high school diploma/GED; and 6-months prior inventory-related experience. Preferred qualifications for IAs include one-year prior inventory-related experience. Required qualifications for ICs are noted on their job description as an associate degree; or equivalent medical-related job experience. Preferred qualifications for ICs include a bachelor's degree in related field; and experience in supply chain or related field. One of the current ICs possesses a bachelor's degree, one possesses an associate degree, and three do not hold any degrees.

The primary duty of the IAs is to monitor daily hospital supplies per the Employer's 96-hour safe zone rule. This rule requires that there is always a stockpile of supplies to last for 96 hours. IAs read bar codes and use the Paragon computer operating system for ordering and maintaining inventory. The Paragon system maintains pre-programmed supply levels and movement of inventory is primarily computer-controlled or it is controlled by Supervisor Drobek and Manager Tranchida based on their advanced knowledge of inventory operations. IAs possess limited discretion to move stock items from one department to another based on department needs and only with management approval. One of the current IAs, Andrew Schultz, works out of the materials office in the central reprocessing/CSR area with IC Allen Randolph. The other current IA, Gail Campbell, shares an office on the first floor of the hospital with IC Bonnie McGarry.

The IC job description generally includes the same essential functions and responsibilities as the IAs with additional functions including utilizing cycle counting procedures to compare physical counts to tracked computer balances to identify gains, losses and value accuracy; working with management to correct inventory errors; working with Central Order

[12] Tranchida is also known as the materials management manager.

Processing to ensure proper stock levels; maintaining inventory data history and preparing activity reports; adjusting reports to effectively manage inventory/supply usage; involvement in quality improvement efforts; inventory computer system maintenance; handling economical disposal of all misdirected, outdated and obsolete goods; and working with sourcing and subsidiary team to implement corporate initiatives for cost saving purposes.

The primary duties of the ICs are to likewise monitor hospital inventory as well as coordinate the purchasing of hospital supplies. One IC is responsible for inventory in each of the following areas: IC Peggy Vaughn – catheterization lab, radiology, interventional radiology and nuclear medicine; IC Allen Randolph – central reprocessing/CSR (regarding handling of surgical instruments which have been used in the OR); IC Todd VanHoutgehen – OR (regarding surgical supplies related primarily to knees, hips, spines, aneurysm clamps, shunts and stents); IC Janice Klos – facilities, grounds and environmental services (EVS); and IC Bonnie McGarry – ICU, nursing units and family birthing center. IC Vaughan works in an office in the cath lab; ICs Randolph and VanHoutgehen share a materials office in the CSR area with IA Schultz; IC Klos works in an office at the Employer's off-site CBO/Glass House facility; and IC McGarry works in an office on the first floor of the hospital near the healing gardens with IA Campbell. Supervisor Drobek has an office in the hospital.

Each of these areas is different and each IC's knowledge is specific to the area assigned. For example, IC Vaughn, who is assigned to the cath lab, uses QSight, a computer software program to monitor trends for supply use in the cath lab. IC VanHouteghen who is assigned to the OR uses e-SIMS, a computer software program to monitor trauma products used in the OR. VanHouteghen also has discretion to order recycled or repurposed supplies for the OR when available. The ICs were trained about one to two days to use these computer programs. The ICs look closely at supply use by physicians and monitor supply deficiencies in the interest of reducing expenses. While they possess authority to order supplies on their own as needed, supply levels in large part are pre-determined by standing orders made by physicians. Moreover, the ICs are limited by supply contracts in place between the Employer and third-party suppliers and they must advise Supervisor Drobek or Tranchida as to any out-of-the ordinary purchases. The parties stipulated that all ICs share the same job duties and responsibilities regardless of work location. The record demonstrates that despite their specialized areas of assignment, the ICs regularly fill in for each other in different areas to cover IC absences. The IAs and ICs do not have any direct patient contact.

On a case-by-case basis, the Board has included purchasing, stockroom and inventory clerks in units consisting of BOC and service and maintenance employees. For example, in ***Valley Hospital***, 220 NLRB 1339, 1343 (1975), the Board found storekeepers in the purchasing personnel department to be BOC employees and not properly included in the petitioned-for non-professional employee unit. The purchasing personnel department was part of the CBO and the storekeepers shared common supervision with the business office employees engaged in office-clerical duties therein. Id. at 1343. See also ***Trumbull Memorial Hospital***, supra at 796-797 (inventory clerks found to be BOCs where they worked in an essentially "business office" capacity and had little in common with clerical employees who work alongside and with a similar objective as employees involved more immediately with the care of patients).

On the other hand, in ***Jewish Hospital of Cincinnati,*** 223 NLRB 614, 622 (1976), the Board found that inventory clerks in the purchasing department were properly included in a service and maintenance unit because of the integration of function with employees properly stipulated to be within the unit. Finally, in ***Charter Hospital of St. Louis,*** 313 NLRB 951, 952 (1994) the Board found the record insufficient to determine whether purchasing clerks were non-professional or BOC employees and therefore determined their eligibility to vote subject to challenge.

The Petitioner argues that the IAs and ICs are either professional employees, based on their educational qualifications and extensive involvement in the Employer's financial systems as well as the exercise of independent judgment in their inventory duties, or BOC employees, based on their close relation to the finance/CBO department. I note that IC Klos works in the Employer's off-site CBO located at the Glass House and further that the materials management department, where all of the IAs and ICs work, is under the wing of the finance department/CBO. The record is silent as to interaction between IC Klos and the other CBO employees. The other ICs and all of the IAs work at the hospital and are under separate supervision from the CBO; there is no evidence of interaction between them and the CBO staff.

To determine whether the IAs and ICs would be more appropriately placed in a separate BOC unit would require further examination including a comparison of the factors relied on by the Board in finding a separate BOC unit appropriate including education, training, functions, location, supervision, wages, interchange and transfer among others. There is limited record evidence to enable such a comparison, especially concerning the actual job duties and responsibilities of the IAs and ICs in relation to the CBO. Thus, the IAs and ICs shall be permitted to vote subject to challenge in the non-professional unit herein, and their voting eligibility will be determined, if necessary, in post-election proceedings.

(7) Medical Coders (MCs)

One MC works in the radiology department and reports directly to Manager of Imaging Services Trevor London. London also directly supervises approximately 90 other employees including imaging assistants, office coordinators, schedulers, CA-2s, and CTs, all of whom are petitioned-for employees, as well as MRI techs, nuclear medicine techs, ultrasound techs, sonographers, and mammographers, all of whom the parties' have agreed should be excluded from a non-professional unit.

The MC job description notes essential functions and responsibilities of the MCs as reviewing patient electronic medical record (EMR), physician orders and radiology reports to verify correct diagnosis code; utilizing computer systems and internet; attending coding meetings with diagnostic imaging management team; and performing statistical analysis of reimbursements and rejection as requested by diagnostic imaging management team.

Required qualifications for MCs are noted on their job description as a high school diploma/GED; eligible for medical coding certification as a Certified Professional Coder (CPC)

or Certified Coding Specialists (CCS)[13] obtained within 12 months of hire; and one-year prior work experience. Preferred qualifications include one to two years post-high school education or training regarding EMRs and/or reimbursement and coding systems; and two years prior work experience.

The primary duties of the MC include verifying that the medical code(s) assigned by medical staff to the patient's EMR matches the patient diagnosis following a diagnostic imaging procedure. To do this, the MC follows a medical CPT[14] code book published annually which sets forth pre-determined medical codes used to report medical, surgical, and diagnostic procedures and services. The MC does not make any decisions with regard to diagnoses and codes, but rather, strictly reviews and verifies data entered and corrects if necessary. Any out-of-the-ordinary issues, such as whether to code as a full or partial procedure, is brought to the attention of London. The record notes that MCs receive on-the-job training regarding patient EMRs as well as the Employer's picture archiving database, called PACS, which houses diagnostic images. The current MC has been in place for several years.

Relying on ***Meriter Hospital***, supra at 598-601, Petitioner argues that the MCs are BOCs rather than non-professional employees and thus should not be included in the petitioned-for unit. I note that ***Meriter Hospital*** involved a petitioned-for unit of technical employees. The employer in that case argued that coder analysts must be included in the unit as technical employees. Without examining the duties and qualifications of the coder analysts, the Board found them to be properly included in the petitioned-for unit as technical employees. There was no discussion regarding their BOC status or the BOC status of any employees.

The Board has typically placed medical records coders in units of either service and maintenance employees or BOCs. In doing so, the Board has considered the placement of employees who "primarily abstract information from patients' charts for a computer," ***Morristown-Hamblen Hospital Association***, 226 NLRB 76, 79 (1976), and employees "involved in abstracting specified data from the records relating to particular diseases, injuries, and medical treatment to be used for hospital statistical and analytical purposes," ***The Baptist Memorial Hospital***, 225 NLRB 1165, 1168 (1976). See also, ***Faribault Clinic,*** supra at 133; ***St. Claude General Hospital***, 219 NLRB 991, 992 (1975). On the other hand, in ***Jewish Hospital of Cincinnati***, supra at 619-620, the Board placed medical records technicians who "primarily abstract and code for computer input information as to diagnosis, surgery and treatment" in a technical unit. In that case, the medical records technicians, also worked with a utilization review committee to review patient records to confirm that procedures were followed, and standards were met which had been set by the physicians on that committee. They also handled all correspondence relating to patient records. Id at 619-620.

To determine whether the MC would be more appropriately placed in a separate BOC or technical unit would require further examination including a comparison of the

[13] The record is silent as to identification of the acronyms CPC and CCS. A google search reveals that CPC stands for Certified Professional Coder and CCS stands for Certified Coding Specialist.
[14] The record is silent as to what CPT stands for. A google search reveals that CPT stands for Current Procedural Terminology (CPT).

factors relied on by the Board in the Rulemaking in finding a separate technical or BOC unit appropriate: education, training, functions, location, supervision, wages, interchange and transfer among others. There is limited record evidence to enable such a comparison. Thus, I will permit the MC to vote subject to challenge.

(8) Patient access representative-1s (PAR-1s), Patient access representative-2s (PAR-2s), Patient access representative-3s (PAR-3s)

Approximately forty-two PARs work in the patient access department managed by Patient Access Manager Lori Loll. Loll is their direct supervisor on the day shift. An afternoon shift supervisor, not identified in the record, who reports to Loll, directly supervises the PARs that work during afternoon hours. The patient access department is under the wing of the finance department/CBO. In this regard, the job description for all PARs notes that that they are part of the CBO/Revenue Cycle and report to CBO leadership.

Each PAR job description notes the position summary as "[s]pecific job responsibilities will be in registration, financial clearance, insurance verification, cashier, etc. as assigned by Revenue Cycle Management."

Required qualifications for PAR-1s are noted on their job description as high school diploma/GED; six-months work experience in patient access, medical billing, or customer service; and Microsoft Office skills. Preferred qualifications include an associate degree in health care, finance, or related area; certification in medical billing or coding; working knowledge of coding systems including CPT, Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases (ICD-10); and one-year experience in revenue cycle. Required qualifications for PAR-2s are noted on their job description as high school diploma/GED; four-years' work experience in patient access, medical billing, or customer service, or an associate degree in related field plus two-years' work experience in patient access or medical billing; clean disciplinary record for internal employees; and Microsoft Office skills. Preferred qualifications include certification in medical billing or coding; and working knowledge of CPT, HCPCS, and ICD-10; and six-years' experience in finance and/or revenue cycle. The PAR-3 job description notes required qualifications as a high school diploma/GED; eight-years' work experience in patient access, medical billing, or customer service, or an associate degree in related field plus four-years' work experience in patient access or medical billing; clean disciplinary record for internal employees; and Microsoft Office skills. Preferred qualifications include certification in medical billing or coding; and working knowledge of CPT, HCPCS, and ICD-10.

There are twenty-eight PAR-1s, seven PAR-2s and seven PAR-3s. The primary difference between the PAR-1s, PAR-2s and PAR-3s is their length of experience and there appears to be little difference in the work performed by each classification. A majority of the PARs perform patient registration duties and work either at a desk in the outpatient registration area of the hospital or in the ED. Registration duties include greeting patients and obtaining patient demographic information such as name, address, and contact information, as well as insurance information to ensure that the patient is properly billed. This data is then entered into the Paragon computer system. The PARs require only minimal on-the-job training to perform

these duties and are trained for about four weeks on-the-job starting out at the hospital quick registration desk for about one week and then transitioning to the outpatient registration area or the ED. The PARs in the ED do not sit at a desk like the PARs in the outpatient registration area. Rather, they go from room to room with a mobile device to collect patient registration information. There is also one PAR that works as a cashier at the cashier's office in the hospital and collects money from patients for services. Additionally, there are approximately four PARs who work in a separate patient finance services office at the hospital and are primarily responsible for verifying inpatient insurance information. Unlike the other PARs, these PARs do not have any direct patient contact. However, all of above the PARs routinely fill in for each other as needed in all areas of assignment. Finally, there are two PAR-1s who work in the outpatient/reference lab. Their duties primarily include registering patients for lab services, and inputting codes for lab tests for billing purposes. As with the MCs above, all codes are pre-determined by physicians and the PARs merely validate and input into the computer system. Like the other PARs, the lab PARs do not require post-high school education, specialized training, certification or licensure. There is limited record evidence that the Employer is in the process of transitioning the lab PARs to the lab dept under the wing of Operations. All of the PARs are regularly scheduled to work Monday through Friday from 7:00 a.m. to 4:30 p.m. and they are on an on-call rotation for all other hours.

Petitioner argues that the PARs are BOCs as they report to the CBO/Revenue Cycle and perform purely business office duties and must not be included in the petitioned-for unit of non-professionals.

In ***William W. Backus Hospital***, supra at 415-416, the Board found that admitting clerks located near the business office but separately supervised were not BOCs. The Board therein noted that although located near the business office, they were physically separated from business office employees, worked primarily with patients' records rather than the materials with which business office employees dealt, and were not supervised by the controller as were the BOC employees. Moreover, they had continual contact with patients and other petitioned-for employees. Id. at 415-416. Likewise, in ***Jewish Hospital of Cincinnati***, supra at 622, the Board found that admitting office employees were not BOCs, noting that they worked primarily with patients' records, performed non-business office functions materially related to unit work, and had substantial contact with patients and unit employees. Finally, in ***Charter Hosp. St. Louis***, supra at 951-953, without making a finding, the Board determined that admissions clerks who performed "pre-certifications" with patients' insurance companies were closer to non-professionals and less likely to be BOCs in comparison to the other business office employees based on their contact with incoming patients to collect data required to be forwarded to the insurance company. As such, I conclude that the PARs should be included in the petitioned-for unit of non-professional employees.

(9) Patient Experience Representatives (PERs)

One PER currently works in the patient advocate department and reports directly to Director of Patient Experience Kimberly Nicholson. One PER position is currently vacant. The PER job description notes essential functions and responsibilities of the PERs as investigating and directing patient inquiries and complaints to appropriate officials; interviewing patients and

other individuals in conducting investigations; reporting on investigation findings; assisting with customer service training program; collecting and distributing employee recognition forms; and working with security regarding lost and found items.

Required qualifications for PERs are noted on their job description as an associate degree in any field of study; and one-year prior office experience working with MS office programs. Preferred qualifications include a bachelor's degree in education, organizational leadership development or related field; three-years prior work experience working with MS office programs; and one-year prior work experience in patient satisfaction, customer services or health care setting.

The current PER works in an office on the first floor of the hospital near Nicholson. The PER acts as a liaison between the hospital medical staff and the patient and conducts investigations related to patient complaints and inquiries regarding matters such as patient care and billing. In this regard, the PER interacts with and obtain statements from patients, family members, other involved individuals, and medical staff related to the patient complaint. Depending on the nature of the complaint, the PER may independently conduct the entire investigation, or may advance the investigation to the involved unit/department for further investigation by the unit/department manager. The record is silent as to what type of complaint would be advanced to the unit/department. At the conclusion of the PER's investigation, the PER is responsible for reporting findings to Nicholson and the unit/department and collecting and logging the findings and report into the Employer's Safety-First computer system/feedback module. In conducting the investigation, neither the PER nor Nicholson have any authority to discipline any involved employees or make recommendations for discipline. Rather, this is within the specific unit/department manager's discretion. PERs are instructed to direct any safety issues involving employees to the Employer's security department. Other PER duties include collecting and logging data regarding Employer initiatives to enhance patient experience and improve the hospital's ratings in that regard; investigating and logging lost property; assisting Nicholson in customer service training; and routine clerical functions in the patient advocate department. Although the current PER has a bachelor's degree in health administration, the position requires only an associate degree, as noted, minimal on-the-job training, and does not require any certification or licensure.

Petitioner argues that the PER position is a professional position based on its required qualifications as well as the PER's considerable exercise of independent judgment in conducting patient investigations. Petitioner also argues, on the opposite end of the spectrum, that the PER position is a BOC position because it does not involve direct patient care.

It appears that the Board has not examined the status of a position like the PER. The record does not demonstrate that the PER position requires any specialized knowledge of an advanced type to deem it professional position within the meaning of Section 2(12) of the Act. ***Samaritan Health Services, Inc.***, supra at 636. Although the record demonstrates that the PER performs some clerical duties related to answering phones, writing emails, and logging lost property, the record does not demonstrate that they perform traditional BOC functions such as handling finances and billing, dealing with Medicare/Medicaid, and other reimbursement systems. Notably, they do have interaction with patients and other nonprofessionals. See

Lincoln Park Nursing & Convalescent Home, Inc., supra at 1164. Thus, the PERs do not appear to be BOCs and I conclude that they should be included in the petitioned-for unit of non-professional employees.

(10) Respiratory Equipment Techs (RETs)

There is one RET that works in the respiratory care area of the respiratory equipment department and reports directly to Manager of Respiratory Care and Neurology Services Jacqueline Phillips.

The RET job description notes essential functions and responsibilities of the RETs as maintaining equipment and troubleshooting problems; assisting in set-up of equipment; maintaining a maintenance log; ensuring equipment is properly working; inventorying supplies; and reporting equipment in need of repair to Plant Operations Department or Clinical Equipment Management department. Required qualifications for RETs are noted on their job description as high school diploma/GED. Preferred qualifications include one-year prior technical work experience.

The RET works in the same area as the respiratory therapists. As the respiratory therapists return from patient rooms to the respiratory care area with used respiratory equipment and machines, the RET cleans, recalibrates, and redresses the equipment and tags it as clean for future use or dirty for further attention. In cleaning and recalibrating the equipment, the RETs follow strict pre-determined guidelines set forth in the manufacturer's operators manual. Any issues regarding repair of respiratory equipment and machines is handled by the BETs and others, as noted above. RET duties also include monitoring respiratory supplies and stock. While the record indicates that the current RET was trained on-the-job, the record is silent as to the extent of such training and who provided such training.

Petitioner argues that the RET is technical employee and must not be included in the petitioned-for unit of non-professional employees. The Employer asserts that the RET is not a technical employee because the position does not require any specialized training or involve the exercise of independent judgment.

The RET position herein does not require any formal education, specialized training, certification, or technical experience of any kind. Performance of the duties described involve basic respiratory machine maintenance and do not involve the exercise of any independent judgment. Compare ***Barnert Memorial Hospital Center***, supra at 779 (respiratory care technicians found to be technical employees based on their duties and qualifications where they administered treatments and operated various types of equipment; and possessed certification in respiratory therapy, and completion of a two-year degree program in respiratory therapy or 64 hours of college credits, plus clinical work in the area). Additionally, in ***Ingalls Memorial Hospital***, 309 NLRB 393 (1992), the Board examined whether the respiratory equipment technician therein would be more appropriately included in a skilled maintenance unit and found that such technician "does not perform skilled maintenance on hospital physical plant systems, or fill the position of a trainee or act as helper or assistant to skilled maintenance employees in the performance of their work." Id. at 399-400. Importantly, the Board noted that the technician in

question "relies heavily on procedural checklists and that electronic and substantial mechanical malfunctions are referred to the Biomedical staff." Id. at 400. Accordingly, I conclude that the RET should be included in the petitioned-for unit of non-professional employees.

(11) Staffing Coordinators (SCs)

Ten SCs work in seven different departments of the hospital. Four SCs work in the clinical support services department, also known as the staffing office; one SC works in the ED; one SC work on the telemetry floor (4-South); one SC works on the med surgery floor (4-West); one SC works in the family birthing center; one SC works in the nursing administration department; and one SC works in the surgical services department. While the record indicates that there is a unit manager (UM) in each department to whom the SCs report, the record is silent as to the identification and duties of these UMs, all of whom report to Director of Patient Care Services Hayes.

The SC job description notes essential functions and responsibilities of the SCs as developing, recording and revising monthly unit staff schedules under the direction and approval of the UM; clerical support; ordering supplies for unit; producing productivity report core data; compiling and maintaining employee attendance records, typing attendance-related disciplines and updating payroll system; and maintaining agency-billing and reporting discrepancies.

Required qualifications for SCs are noted on their job description as a high school diploma/GED. Preferred qualifications include one-year clerical experience; or a business-related associates degree.

The primary role of the SCs is to ensure that each unit is appropriately staffed. To do this, the SCs are trained on-the-job for about one month to input schedules into the Employer's ClairVia computer scheduling system.[15] They are also trained for about two hours in using the One-Call computer program to input automated messages for transmission to employees by text or a phone call regarding available overtime and open shifts. The SCs also perform data entry into the Kronos payroll system. The parties stipulated that regardless of the specific department/unit assigned to, all SCs share the same duties and qualifications.

In its brief, the Petitioner argues that the SCs, like the MSCs, might be professional employees based on the education requirements requiring them to have an associate degree. The record, however, demonstrates that the education requirements for the SCs is not an associate degree, but a high school diploma/GED. Petitioner alternatively argues that the SCs are not appropriate for inclusion in the petitioned for unit because they are BOCs. The Employer argues that the scheduling duties of the SCs are dictated by pre-determined Employer guidelines and staffing matrices and do not involve the exercise of independent judgment. Thus, they are non-professional employees and should be included in the unit herein.

The record herein does not contain evidence that the SCs perform any functions associated with the business office employees in the CBO. Rather, they perform scheduling/staffing duties in the main hospital under the general umbrella of nursing operations,

[15] The Employer is currently transitioning from the ClairVia scheduling program to Kronos Advanced Scheduler.

interact with and share common supervision with other petitioned-for employees, and perform functions related to patient care. See ***Lincoln Park Nursing Home***, supra at 1163-1164. Accordingly, I conclude that the SC should be included in the petitioned-for unit of non-professional employees.

(12) Systems Specialists (SSs)

One SS works in an office in the clinical support services department located on the fifth floor of the hospital and reports directly to Director of Patient Care Services Hayes. The SS job description notes essential functions and responsibilities of the SSs as monitoring and maintaining the scheduling system to ensure accurate employee time and attendance records; providing education and training on the scheduling system; investigating and working with system experts to resolve errors with scheduling systems; and assisting in development of processes and procedures related to scheduling system and recommending changes to increase effectiveness.

Required qualifications for SSs are noted on their job description as a business-related associate degree; and two-years health care experience. Preferred qualifications include prior experience with staffing/scheduling systems, onboarding orientation or training activities. The current SS possesses an associate degree and prior experience in the Kronos payroll and scheduling systems.

The SS provides support to and assists SCs who work in the clinical support services department/staffing office and on the nursing units. However, the record is unclear regarding the extent, if any, of the physical contact and interaction between the SS and the SCs working in the staffing office and on the units. The SS's main support role is related to software management. In this regard, the SS primarily acts as a liaison between the Employer and the software companies that provide data entry computer systems to the Employer including its ClairVia, One-Call and Kronos software systems. The SS regularly attends periodic one to two-week webinar training programs conducted by the third-party software companies and acts as the Employer's designated "administrator" of these software programs. The record mentions that the current SS trains other employees in these systems, however, it is silent as to which employees she trains. The SS has no authority to make decisions concerning the Employer's software systems. Rather, any systems issues resulting in any hospital-wide impact is automatically forwarded to Hayes, who then reports such issue to her superior (Vice President of Patient Care Services Julia Libcke), the Employer's IT department,[16] or the involved software company. The SS does not have any direct patient contact.

Petitioner argues that the SS position is a finance position involving the payroll system which requires specialized training and should be included in either a BOC or professional unit. While acknowledging that the SS evaluates software program issues and resolves some of these issues, the Employer argues that this does not involve the exercise of independent judgment because anything of any major hospital-wide impact is automatically forwarded to upper manager, the Employer's IT department, or the involved software company.

[16] The Employer's IT department is called ATOS but the record does not state what ATOS stands for.

The SS works in the main hospital in a department in which other petitioned-for employees work and is not part of the IT department; reports to a supervisor who supervises other unit employees; and has some contact with unit employees in the course of troubleshooting issues regarding information systems in the petitioned-for employees' areas. The SS does not perform traditional BOC work. See ***Lincoln Park***, supra at 1165. Accordingly, I conclude that the SS should be included in the petitioned-for unit of non-professional employees.

D. The Employer's Arguments regarding Residual Unit and the Patient Safety Associates (PSAs) and Patient Sitter-2s (PS2s)

The Employer and Petitioner stipulated that the PSAs and PS-2s are non-professional employees. However, the Employer argues that these employees must not be included in any non-professional unit found to be appropriate herein because they properly belong in the existing AFSCME-represented bargaining unit based on their overwhelming community of interest with the AFSCME-represented PCAs. The Employer specifically points to the interaction between the petitioned-for PSAs and PS-2s and the AFSCME-represented patient care associates (PCAs). Petitioner disagrees and argues that it has petitioned for an appropriate "residual" unit of all non-represented non-professional employees.

There are approximately fifty-three (53) PSAs and six PS-2s who are part of the clinical support services department under the wing of Director of Patient Care Services Doreen Hayes. The PSAs and PS-2s are assigned to individual units throughout the hospital as well as the float pool. The record indicates that they directly report to the unit managers and supervisors of the unit they are assigned to, all of whom report ultimately to Director Hayes.

Required qualifications for PSAs and PS-2s are noted in each of their job description as a high school diploma/GED. Preferred qualifications include completion of a nursing assistant program or one-year related experience for PSAs and one-year of prior acute care/medical experience for PS-2s.

The primary duties of the PSAs and PS-2s is to sit with at-risk patients in their hospital room and alert a nurse or security to any at-risk behavior. At-risk patients can fall into the categories of dementia patients, behavioral health/psychiatric patients, or neurological patients. The PSAs and PS-2s are strictly directed to never lose sight of the patient and they can never be more than two feet away from the patient. While sitting in the patient's room they do not perform patient care duties such as taking vitals or assessing the patient's condition. Rather, those patient care duties are routinely performed by the AFSCME-represented PCAs. The PSAs and PS-2s are trained on-the-job by a clinical educator for about eight hours. The minimum hourly wage rate for a PSA is $9.45 and for a PS-2 is $10.12. The Employer's job description for PSA and PS2 is consistent with the above duties.

The difference between the PSAs and PS-2s is that the PS-2s are additionally trained to monitor at-risk patients from outside the patient's room via the Employer's AvaSys Telesitter monitoring system. The PS-2s then transmit verbal directions to the patient or to a nurse as needed. All PSAs are eligible to receiving training to become a PS-2, however, not all are

successful. Successful completion of training to become a PS-2 is determined by a clinical educator/trainer.

Like the PSAs and PS-2s, the AFCSME-represented PCAs also work on individual units throughout the hospital as well as in the float pool. The PCA job description is not included in the record and there is limited record testimony as to the actual duties and responsibilities of the PCAs. Their primary duties appear to be traditional certified nursing assistant (CNA) duties related to patient-care including taking vitals and assessing overall patient conditions. In this regard, the record indicates that most of the PCAs have been trained in a certified nursing assistant program offered by the American Red Cross or a community college. While the record demonstrates that the PCAs are also trained to and do fill in for PSAs as needed, on a regular and sometimes daily basis, it is silent as to the amount of time the PCAs perform PSA duties in comparison to their own duties. The AFSCME collective bargaining agreement permits the Employer to reassign PCAs to different areas as needed. When this happens, the PCA earns her/his regular hourly wage rate which is about $4.00 per hour more than the PSA wage rate. There is also limited record evidence that a PCA can volunteer to work as a PSA for overtime and extra shifts. When this happens, the PCA earns the PSA wage rate. The minimum hourly wage rate for a PCA is $13.10.

In its brief, the Employer acknowledges ***St. Mary's Duluth Clinic***, 332 NLRB 1419 (2000), in which the Board determined that "a nonincumbent union [like Petitioner herein] may represent a residual unit of employees in the healthcare industry." Id. at 1420. However, the Employer urges that such a finding is not appropriate here, where there is significant and undisputed evidence confirming an overwhelming community of interest between the petitioned-for employees and the employees included in the existing AFSCME bargaining unit. The Employer specifically points to the interaction between the petitioned-for PSAs and PS-2s and the AFSCME-represented PCAs in support of its argument that the Board's finding in ***St. Mary's Duluth*** is inapplicable.

In ***St. Mary's Duluth Clinic***, the Board determined that at an acute-care hospital where there is a non-conforming bargaining unit consisting of some, but not all, of the employees who would otherwise constitute an appropriate unit under the Board's Health Care Rule, a different union may petition for a separate residual unit of the remaining non-represented employees, provided that the petitioned-for unit is an appropriate residual unit. Id. at 1420-1422. I do not agree with the Employer that the adjudication of facts in this proceeding should result in a finding opposite to this finding. To the contrary, this matter presents no fact or issues in contrast to those presented in that case or subsequent cases relying on it. See also ***Kaiser Foundation Health Plan of Colorado,*** 333 NLRB 557, 558 (2001). As the Board noted, "a dismissal of the petition for a residual unit would necessarily force … [petitioned-for] employees to remain unrepresented for the duration of the incumbent-employer contract. Depending upon the length of the existing collective-bargaining agreement, the residual employees could be denied the opportunity to choose a bargaining representative for a period of months or even years." Id. at 1421. I also do not agree with the Employer that at a minimum it must exclude the PSAs and PS-2s from any non-professional unit of employees found appropriate herein. This would result in the disenfranchisement of employees whom the parties have stipulated are non-professional. Such result would be contrary to Board law. ***St. Mary's Duluth Clinic***, supra at 1421. Finally, I

do not find the Employer's record evidence demonstrating that by letter dated June 27, 2019, AFSCME requested the Employer to voluntarily recognize all employees in the classification of "patient access clerk"[17] to be probative or persuasive in finding the petitioned-for residual unit to be inappropriate in any way.

IV. Conclusion

Based upon the entire record in this matter[18] and in accordance with the discussion above, I conclude and find as follows:

1. The Hearing Officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce[19] within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction in this case.

3. The Petitioner is a labor organization within the meaning of Section 2(5) of the Act and claims to represent certain employees of the Employer.[20]

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. The following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> All full-time and regular part-time bed control specialists; administrative assistants, imaging assistants; clerical associate-1s; clerical associate-2s; gift shop clerks; clinical care systems coordinators; office coordinators; dispatchers; couriers; EEG techs; operators; patient liaison meta bariatric; schedulers; surgical boarders; surgical supply specialists; cardiographic techs, critical care techs, lab assistants, perioperative techs, pharmacy tech-1s; pharmacy tech-2s; patient access representative-1s; patient access representative-2s; patient access representative-3s; patient experience representatives; respiratory equipment techs; staffing coordinators; patient bed sitter-2s, patient safety coordinators and systems specialists; *but excluding* all biomedical tech-1s; biomedical tech-2s; biomedical tech-3s; Accountant II; cardiovascular invasive specialist reg; case manager RN; clinical

[17] AFSCME apparently erroneously referred to the current PCAs by their former classification known as patient access clerks.
[18] The Employer and Petitioner filed briefs which were carefully considered.
[19] The Employer, during the calendar year 2018, in conducting its operations derived gross revenues in excess of $250,000. During the same period of time, the Employer purchased and received goods valued in excess of $5,000 directly from points located outside the State of Michigan, as stipulated by the parties at the hearing.
[20] Both parties stipulated that the Petitioner is a labor organization within the meaning of the Act.

information specialist; clinical pharmacy specialist; clinical specialty coordinator; computer tomography techno; coordinated emergency preparedness; computer tomography techno lead; clinical transformation specialist; coordinated metabolic bariatric; coordinated surgical board; cytotechnologist; educator diabetes RN; educator patient care services; educator patient care service lead; executive assistant; executive assistant senior; exercise physiologist; imaging services instructor; infection preventionist; laboratory marketing rep; lactation consultant; librarian; mammography techno; mammography techno lead; marketing communication specialist; medical staff credentialing specialist; media relations specialist; medical laboratory tech; medical assistant; MRI technologist; MTQIP clinical reviewer; medical technologist; nurse extern; nurse intern; nuclear medicine technologist; nurse navigator breast health; nurse practitioner specialty; OB technician II; occupational therapist; pathologist assistant; pharmacist; pharmacist lead; pharmacy buyer; pharmacy intern; physical therapist; physical therapist assistant; physical therapist assistant lead; physician liaison; polysomnographic technologist; polysomnographic technologist lead; preadmission testing techs; program managers; clinical risk patient safety; quality improvement specialist; radiology technologist; RN first assistant; respiratory intern; respiratory therapist reg; respiratory reg lead; social worker MSW; sonographer; sonographer cardiac; sonographer cardiac lead ; sonographer lead; sonographer vascular reg; special procedure technologist; speech language pathologist; surgical tech; trauma data analyst; trauma performance IMP specialist; utilization review AP specialist RN; utilization review specialist; all other employees, managerial employees, temporary employees, contracted employees, confidential employees, guards and supervisors as defined in the Act.

DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the unit found appropriate above. Employees will vote whether or not they wish to be represented for purposes of collective bargaining by Local 40, RN Staff Council, Office and Professional Employees International Union (OPEIU), AFL-CIO.[21]

[21] An administrative investigation confirmed that the Petitioner's showing of interest was sufficient even in the expanded unit found appropriate herein.

A. Election Details

The election will be held on **August 28, 2019** from **5:30 a.m.-8:00 a.m.; 2:00 p.m.-4:00p.m. and 5:30 p.m.-7:00 p.m.** in a classroom in the basement of the main hospital located at 1000 Harrington Street, Mt. Clemens, Michigan.

B. Voting Eligibility

Eligible to vote are those in the unit who were employed during the payroll period ending **August 3, 2019** including employees who did not work during that period because they were ill, on vacation, or temporarily laid off. Also eligible to vote are all employees in the included classifications who have worked an average of four (4) hours or more per week during the 13 weeks immediately preceding the eligibility date for the election.

Employees engaged in an economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, in an economic strike that commenced less than 12 months before the election date, employees engaged in such strike who have retained their status as strikers but who have been permanently replaced, as well as their replacements, are eligible to vote. Unit employees in the military services of the United States may vote if they appear in person at the polls.

OTHERS PERMITTED TO VOTE: The anesthesia techs, endoscopy techs, academic program administrator-1s; academic program administrator-2s; billing clerks; medical staff services coordinators; graduate medical education specialists; inventory assistants; inventory coordinators; medical coders; and audit analysts may vote in the election but their ballots will be challenged since their eligibility has not been resolved. No decision has been made regarding whether the individuals in these classifications or groups are included in, or excluded from, the bargaining unit. The eligibility or inclusion of these individuals will be resolved, if necessary, following the election.

Ineligible to vote are (1) employees who have quit or been discharged for cause since the designated payroll period; (2) striking employees who have been discharged for cause since the strike began and who have not been rehired or reinstated before the election date; and (3) employees who are engaged in an economic strike that began more than 12 months before the election date and who have been permanently replaced.

C. Voter List

As required by Section 102.67(l) of the Board's Rules and Regulations, the Employer must provide the Regional Director and parties named in this decision a list of the full names, work locations, shifts, job classifications, and contact information (including home addresses, available personal email addresses, and available home and personal cell telephone numbers) of all eligible voters.

To be timely filed and served, the list must be *received* by the regional director and the parties by **August 12, 2019**. The list must be accompanied by a certificate of service showing service on all parties. **The region will no longer serve the voter list.**

Unless the Employer certifies that it does not possess the capacity to produce the list in the required form, the list must be provided in a table in a Microsoft Word file (.doc or docx) or a file that is compatible with Microsoft Word (.doc or docx). The first column of the list must begin with each employee's last name and the list must be alphabetized (overall or by department) by last name. Because the list will be used during the election, the font size of the list must be the equivalent of Times New Roman 10 or larger. That font does not need to be used but the font must be that size or larger. A sample, optional form for the list is provided on the NLRB website at www.nlrb.gov/what-we-do/conduct-elections/representation-case-rules-effective-april-14-2015.

When feasible, the list shall be filed electronically with the Region and served electronically on the other parties named in this decision. The list may be electronically filed with the Region by using the E-filing system on the Agency's website at www.nlrb.gov. Once the website is accessed, click on **E-File Documents**, enter the NLRB Case Number, and follow the detailed instructions.

Failure to comply with the above requirements will be grounds for setting aside the election whenever proper and timely objections are filed. However, the Employer may not object to the failure to file or serve the list within the specified time or in the proper format if it is responsible for the failure.

No party shall use the voter list for purposes other than the representation proceeding, Board proceedings arising from it, and related matters.

D. Posting of Notices of Election

Pursuant to Section 102.67(k) of the Board's Rules, the Employer must post copies of the Notice of Election accompanying this Decision in conspicuous places, including all places where notices to employees in the unit found appropriate are customarily posted. The Notice must be posted so all pages of the Notice are simultaneously visible. In addition, if the Employer customarily communicates electronically with some or all of the employees in the unit found appropriate, the Employer must also distribute the Notice of Election electronically to those employees. The Employer must post copies of the Notice at least 3 full working days prior to 12:01 a.m. of the day of the election and copies must remain posted until the end of the election. For purposes of posting, working day means an entire 24-hour period excluding Saturdays, Sundays, and holidays. However, a party shall be estopped from objecting to the nonposting of notices if it is responsible for the nonposting, and likewise shall be estopped from objecting to the nondistribution of notices if it is responsible for the nondistribution.

Failure to follow the posting requirements set forth above will be grounds for setting aside the election if proper and timely objections are filed.

RIGHT TO REQUEST REVIEW

Pursuant to Section 102.67 of the Board's Rules and Regulations, a request for review may be filed with the Board at any time following the issuance of this Decision until 14 days after a final disposition of the proceeding by the Regional Director. Accordingly, a party is not precluded from filing a request for review of this decision after the election on the grounds that it did not file a request for review of this Decision prior to the election. The request for review must conform to the requirements of Section 102.67 of the Board's Rules and Regulations.

A request for review may be E-Filed through the Agency's website but may not be filed by facsimile. To E-File the request for review, go to www.nlrb.gov, select E-File Documents, enter the NLRB Case Number, and follow the detailed instructions. If not E-Filed, the request for review should be addressed to the Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570-0001. A party filing a request for review must serve a copy of the request on the other parties and file a copy with the Regional Director. A certificate of service must be filed with the Board together with the request for review.

Neither the filing of a request for review nor the Board's granting a request for review will stay the election in this matter unless specifically ordered by the Board.

Dated: August 8, 2019

Terry Morgan
Regional Director
National Labor Relations Board - Region 7
Patrick V. McNamara Federal Building
477 Michigan Avenue, Room 300
Detroit, MI 48226